Washington State
Department of Social
& Health Services

Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

October - December 2005

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Children's Administration Child Fatality Report
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INTRODUCTION

This is the October - December 2005 Quarterly Child Fatality Report provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature. This report summarizes the 22 reviews that were completed during the fourth quarter of 2005. Seventeen of these cases were fatalities that occurred in 2004 and five were fatalities that occurred in 2005. All of these fatalities were reviewed by a regional Child Fatality Review Team.

Child Fatality Reviews are conducted when children die unexpectedly and their families had an open case or received services from the Children's Administration (CA) within 12 months of their death. Child Fatality Reviews consist of a review of the case file, identification of practice, policy or system issues, recommendations, and development of a work plan to address the identified issues. A review team can be as few as two individuals on cases where the death is clearly accidental in nature, to a larger multi-disciplinary committee where the child's death may be the result of abuse and/or neglect by a parent or guardian.

An Executive Child Fatality Review by policy is a special review convened by CA's Assistant Secretary. The Executive Child Fatality Review may be requested when a dependent child dies as a result of abuse and/or neglect by their parent or caretaker, or a non-dependent child dies of abuse and/or neglect on an open, active case or in a licensed facility. In the Executive Child Fatality Review, members of the review committee are individuals who did not have any involvement in the case and represent areas of expertise that are pertinent to the case. Committee members may include legislators or others as determined by the Assistant Secretary.

It is often many months following the death of a child before the fatality review is completed. This is due to Child Fatality Reviews requiring a multi-agency effort in gathering complete reports and findings. It is necessary to wait until all information is compiled in order to ensure a thorough review of the case, even when this means having an extended timeline for completion.

The chart below provides the number of fatalities reported to CA, and the number of reviews completed and pending for 2004 and 2005. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, we may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for 2004 and 2005			
Year	Total Fatalities Reported to Date	Completed Fatality Reviews	Pending Fatality Reviews
2004	60	49	11
2005	54	8	46

The numbering for the Child Fatality Reviews in this report begin with #04-35. This indicates the fatality occurred in 2004 and is the 35th report completed for that year. The number is assigned when the Child Fatality Review and report by the CPS Program Manager is completed.

The reviews included in this quarterly report discuss fatalities that occurred in the following Regions:

2 reports are from Region 1—Spokane
3 reports are from Region 2—Tri Cities (2) and Yakima
4 reports are from Region 3—Bellingham, Everett, Lynnwood, and Sky Valley
3 reports are from Region 5—Bremerton (2) and Tacoma
10 reports are from Region 6—Aberdeen, Centralia, Kelso (3), Tumwater, and Vancouver (4)

In addition to the quarterly Child Fatality Reviews, CA will be completing an Annual Child Fatality Report which will provide statistical information on child fatalities that occurred throughout the entire year. The next annual Child Fatality Report will be for the year 2003.

Child Fatality Review #04-35
Region 6
Kelso Office

Case Overview

This two-month-old Caucasian female died on September 26, 2004 due to asphyxiation.

On September 27, 2004, Division of Children and Family Services (DCFS) intake was notified of the infant's death by the Longview Police Department (LPD). LPD requested DCFS records. An LPD officer provided DCFS with an initial report. The report indicates the baby was found in the bedroom not breathing. The report indicates the parents were interviewed at the scene, and informed LPD the child had a history of sleep apnea. The parents state the child woke up crying, and the mother changed and fed the baby. The baby fell back to sleep on the mother's chest. The father was sleeping on a separate mattress and woke up observing the baby face down next to the mother. The father stated he could see the child was not breathing. He blew into the baby's face a couple times and called 911. LPD's report states the following, "No obvious injuries, treated at the scene by ambulance crew and transported to St. John's Hospital where the emergency department staff worked on the baby. The doctor advised there was no indication that the death had been anything other than natural."

This case was open at the time of the child's death with services being provided to the family. Contact with the child's medical doctor indicated that he had no concerns regarding the child's weight and stated that she was not failure to thrive as indicated in the August 20, 2004 referral. The doctor further stated the mother has attended all appointments scheduled, arrives on time and appears to follow the advice given. The mother had indicated to the doctor concerns about the child's sleep apnea. The case was staffed on September 23, 2004 and continued services were offered to the mother. The mother was working with Women, Infant and Children (WIC) for nutrition counseling.

The mother has had three significant DCFS interventions. The first was at the birth of her first child where services were offered and allegations determined to be unfounded. A year later a referral was received regarding possible drug use and hygiene of the child. An investigation was completed, and the case was closed as unfounded. The last referral prior to this child's death contained allegations of failure to thrive regarding the newborn, condition of the home, and the mother's untreated mental health issues. The social worker made the initial face-to-face contact with the child and mother assessing the allegations and family needs. The social worker followed up with a call to the medical doctor who reported no concerns of failure-to-thrive, but indicated some concern about the mother's cognitive ability. Although the safety assessment did not indicate that there was a safety concern, the social worker wanted to continue to support the mother through a voluntary service/safety plan. The social worker staffed the case with the supervisor who agreed to transfer the case to a worker to monitor the safety/service plan. The case was assigned to the supervisor just prior to the child's death. The case remained open for services and follow-up after the infant child's death. The mother has had services offered and provided and appears to have followed through with those services. Although her mental health

history continues to be reported as a concern no specific allegations regarding assault to her children has ever been reported.

Issues and Recommendations

This child's death was a direct result of co-sleeping with the parent. It is recommended that Children's Administration consider working with the Department of Health and Health Districts to discuss the need for an educational program much like the "Back to Sleep" campaign to educate parents on the potential dangers of co-sleeping.

Child Fatality Review #04-36
Region 6
Aberdeen Office

Case Overview

This 17-year-old Native American female died in a car accident on July 3, 2004. She died at Harborview Medical Center in Seattle of injuries to the head and trunk after the car she was riding in apparently slid out of control, according to an investigator from the King County Medical Examiner's Office. The accident occurred around 2:00 p.m. on a logging road near Aberdeen.

This child had been a Family Reconciliation Services (FRS) client from March 5, 2003 to July 22, 2003. The referral was for running away and using alcohol and drugs. The mother petitioned the court and was granted an At Risk Youth (ARY) order on March 27, 2003. On May 20, 2003, the mother reported there was a hearing the next day for several contempt charges. This child had been charged with Unlawful Use of a Motor Vehicle (UUMV) of her parent's car. The mother asked for alcohol/drug and mental health services. On May 22, 2003, the youth was detained and completed an alcohol/drug evaluation in detention. The mother requested FRS Phase II counseling which was provided and completed in June. This youth was seen in counseling and outpatient alcohol/drug treatment. The mother was using ARY contempt orders in addition to counseling and family discipline. FRS was closed with the ARY order in place and after completion of FRS Phase II. This fatality report is being submitted now because a check of CAMIS history indicated that FRS was inactive at the end of March 2003, but a later review of SERs indicated that FRS Phase II ended approximately the end of June and the FRS case closed in July 2003. The accidental death occurred just short of one year later on July 3, 2004.

The family consists of the mother, age 44, the father, age 55, and a brother, age 16, and the decedent. The parents have been married for 15 years with the mother reporting their marriage is going well. The parents used to engage in domestic violence and alcohol abuse. They obtained domestic violence and substance abuse treatment long before the involvement of FRS. This youth was popular with peers, getting along well with almost everybody. She was making poor choices and was negatively influenced by new friends. Her mother suspected her of using crank, marijuana and alcohol, and her mother reported on two occasions that her daughter smelled of alcohol. She was referred to the school's drug and alcohol program. The mother stated she and her daughter argued over her sneaking boys into her bedroom. She was easily influenced under peer pressure to be a "rescuer." She had struggled with feelings of grief and loss over the death of her maternal grandfather. There were no Child Protective Services (CPS) referrals on this family. ARY was ordered on March 27, 2003. The court ordered this youth to complete a drug and alcohol evaluation while in detention for contempt on May 22, 2003. Prior to FRS Phase II services, the family participated in counseling. It was reported that this intervention had little success with the family.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-37
Region 6
Vancouver Office

Case Overview

This two-month-old Caucasian male child died on July 10, 2004 due to Sudden Unexplained Infant Death. The case was open at the time of this child's death. The assigned social worker was notified by the parent's roommate that the infant was found dead early Saturday morning on July 10, 2004. The parent's roommate reported that she had assisted the mother by bringing a bottle to her during the night. The baby was in his bassinet at the time. The baby was reported to have been dead in the parent's bed in the morning. The mother did not acknowledge sleeping with the baby, per the report of the medical examiner. The medical examiner said that the mother told the investigating officer that she had been told by the assigned Child Protective Services (CPS) social worker not to sleep with the baby. At this time, the medical examiner says the cause of death is Sudden Unexplained Infant Death, manner undetermined, with a possible contributing factor of co-sleeping. According to both the mother's roommate and her treatment providers, the mother had been following through with services, and there were no indications of any drug use.

There were five referrals on the mother prior to the death of this son. A referral received on October 4, 2000 was investigated with a finding of founded against the mother. This referral resulted in dependency court action. Concerns have included the mother's drug abuse, and involvement in homes where methamphetamine was being manufactured. Despite the concern about the mother's leaving her in-patient treatment program early, she appeared to be following through on the recommended services. She admitted to leaving the program a month early because of homesickness and wanting to be closer to her support network after the baby was born. She denied having relapsed and denied that a wish to use drugs motivated her leaving. In fact, a random urinalysis requested at the time of the initial unannounced visit was negative for all substances. The mother had reinitiated services through Positive Start and was poised to return to the Mom's Group at Recovery Northwest. The mother's roommate affirmed there was no drug involvement and reiterated that was a requirement for the mother to continue to reside with her. The roommate states that the mother was attentive to her baby, and there were no problems with her failure to respond to him at night. Both pointed out that the close proximity of the bassinet to the bed afforded easy access. The mother had scheduled his two month check up.

Services that the mother has engaged in include mental health, substance abuse, public health, and parenting classes.

Issues and Recommendations

I. Practice Issue

A. Issue: The social worker counseled the parent about co-sleeping. The parent acknowledges the social worker did talk to her about it.

*Recommendation: No recommendation*s

Child Fatality Review #04-38
Region 6
Kelso Office

Case Overview

This three-month-old Caucasian male child died on November 15, 2004 due to accidental death by asphyxiation.

On November 15, 2004, a referral was called in to Central Intake by a St. John Medical Center social worker to report that this three-month-old was declared dead at 2:35 a.m. American Medical Response (AMR), Longview Fire Department, and Longview Police Department responded to the residence. The three-month-old child was found face down on the floor. The ambulance crew was asked if child abuse or neglect was suspected, and they responded with "not sure." The ambulance crew told the referrer that there were two males and two females at the residence. The referrer was told the two females were "freaking out" and that the home was in disarray. Two other children were present, an 18-month-old and an eight-year-old.

The mother of the decedent has a long history of child abuse and neglect as a child, having been physically abused by her mother's boyfriend and spending most of nine years in foster care until she turned 18. Previous referrals pertaining to the father involve a boy from a previous relationship. Recent referrals involving both parents primarily concerned the care and well-being of the 18-month-old, a medically fragile child whose prognosis is not good for longevity. The parents obtained appropriate medical care with the assistance of the assigned Division of Children and Family Services (DCFS) social worker.

Suspicious rib fractures discovered during the autopsy increased the suspicion of abuse or neglect of the 18-month-old. Both parents passed polygraph tests regarding asphyxiation and rib fractures to the decedent. Medical experts were consulted regarding the rib fractures found during autopsy. A review of the medical x-ray films by an expert doctor in the area of child abuse and neglect found no evidence of rib fractures. The doctor stated the x-rays had been "over read."

DCFS received the police report regarding this incident on November 15, 2004 which stated the following, “police responded to address at 1:44a.m. for a fire department assist. The infant was blue in color and motionless. AMR personnel administered CPR and medical aid. Mother told officer that she had fed child his normal formula about 2 hours ago and had put him down to sleep on an upstairs mattress. The father thought he heard the baby crying and mother checked on him. Baby sighed and moved his arms, so she felt he was fine. Baby was lying near the edge of the mattress on a child's sleeping bag. About an hour later the father went upstairs to go to bed and yelled for the mother. He opened the door to their room and did not see the baby lying on the bed at first. He then saw his legs protruding from under a portable playpen that the 18-month-old child sleeps in. He picked up the playpen and set it on the bed (mattress) and grabbed the baby. The baby was cold to the touch and not breathing. Father tried to do CPR but didn't know what he was doing; when he blew in the baby’s mouth it made a gurgling sound, so he stopped because he thought he was going to hurt him. He ran downstairs with the baby to call 911. While they were waiting for the paramedics, they tried more CPR but still didn't know what they were

doing. At the hospital, Law Enforcement talked with the ER doctor. The three-month-old was deceased and lying in the trauma room. Emergency Room doctor told the Law Enforcement Officer that he did not find any signs of external trauma on the child and it appeared that he died of asphyxiation, possibly a SIDS death. However, the officer later talked with the coroner, who 'was concerned with signs of possible child neglect. She believed that the neglect may have been a contributing factor in the baby's death. The coroner showed me how dirt was accumulated under the baby's fingernails, and in the folds of his skin. This was consistent with not having been bathed in a great length of time. There was also a layer on the baby's head that was also from not being bathed.'"

Police officers took photos of the scene of the death and took property (blanket, portable crib, and diaper into evidence). There was no description in the police report as to any "disarray." A sketch of the room showed the bedroom containing the mattress, play pen, a TV, car seats and clothes, and plywood for the bed leaned against a wall. On the mattress were an infant blanket at the end near the play pen and bedding and pillows at the opposite end (what would be the head of the bed). Later information (since receipt of the initial police report) indicates that police were concerned about possible broken bones or fractured ribs on the child. Police went back out to the residence to interview the adults. An autopsy was done on the deceased child.

There were two prior screened referrals. The first referral (#1466172) was dated November 13, 2003 and alleged medical neglect of the then six-month-old child. The second screened referral (#1549496) was on September 12, 2004 and alleged general neglect of the three children in the home. Both referrals were investigated by a social worker. Safety assessments (#399503 and #450169) were completed on December 2, 2003 and September 13, 2004 with all safety factors determined to be "not indicated" on both assessments. Although the investigative assessments have not yet been completed, the assigned social worker has stated that both allegations would be "unfounded." These referrals were staffed with various medical professionals from Cowlitz and Lewis Counties and reviewed by the Kidscreen Specialist, and DCFS medical consultant.

The 18-month-old was the primary focus of these two previous screened-in referrals on November 13, 2003 and September 12, 2004 as she is disabled with congenital anomalies. She has had significant reflux and has aspirated fluids in the past. The child was fed through a G-tube but currently is able to feed herself normally. She is still medically fragile and is not expected to live to adulthood. Her congenital condition will ultimately cause her death. She has renal failure and would require a kidney transplant at some time. Her internal organs are growing, and her body is not.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-39
Region 6
Kelso Office

Case Overview

This two-month-old Hispanic male child died in his home while asleep on the couch with his mother on November 22, 2004. The child was in the care of his birth mother. The child was seen by a pediatrician a week prior for a routine medical appointment, and concerns for colic were addressed. On November 22, 2004, the child was said to be irritable and the mother laid on the couch with the child, and the child stopped breathing. Nine-one-one was called and law enforcement and medical crews responded. Life support was administered. Contact was made to St. Johns Hospital Emergency Department, and a decision was made to discontinue the life support measure, and the child was pronounced dead at the scene and not transported to the hospital. An autopsy was completed the evening of November 22, 2004, and no official cause of death was received at the time of this report. A Kelso police officer was on the scene, and he stated the preliminary report indicates the manner of death is inconclusive. An information only referral was generated as a result of the death.

Collateral contact was made to the child's doctor on November 23, 2004. The doctor reports the mother was very attentive to the child's routine medical care and additional visits as needed. The doctor stated the child was seen the week before the fatality and concerns for colic were addressed. The doctor states the child's formula was changed at this visit. The doctor states the only concerns he had is the age of the mother and the fact that the birth father is in prison out of state for ten years. The doctor states he has observed no concerns of abuse or neglect and had no reason to make a report to Child Protective Services (CPS).

There was a referral received on July 23, 2004 alleging drug use by the mother during pregnancy. It was screened in and a letter was sent to mother offering services and discussing the dangers of drug use during pregnancy. The mother and baby were both tested at the baby's birth and were both negative for drugs. No concerns were reported by the hospital.

The mother has Division of Children and Family Services (DCFS) history as a child with CPS, Family Reconciliation Services (FRS) and Child Welfare Services (CWS) with 13 prior referrals in the FRS and CWS programs. One CPS referral was with the mother as a victim. This CPS referral was inconclusive.

Issues and Recommendations

I. Practice Issue

A. Issue: The Kelso office has had a "Heads Up" baby practice for some time. The referrals were screened in, and this was not in compliance with Children's Administration policy.

Recommendation: Follow current Children's Administration policy regarding prenatal substance abuse referrals. Kelso has changed their practice to comply with statewide policy.

Child Fatality Review #04-40
Region 6
Vancouver Office

Case Overview

This five-month-old Caucasian male died on November 26, 2004 due to unknown causes. This child was born medically fragile on June 17, 2004. At birth, he weighed four pounds and had a serious congenital heart defect that required surgery when the child reached seven pounds.

The history of the mother reflects that she had used alcohol and smoked during her pregnancy with this child. A referral was received on November 18, 2004 alleging medical neglect and possible problems of substance abuse by the parents. The social worker was attempting to locate the parents after having tried the previous week. The social worker called the paternal grandmother in the morning. The grandmother said that she had called father who yelled at her that the baby had died on Friday night.

The Child Abuse Intervention Center (CAIC) was contacted and found out that the child had died on Friday night. The Clark County Sheriff's Department Crisis Response Team reported the child's death to the CAIC. The Sheriff's Department made an initial determination that the child's death was not due to child abuse or neglect.

The Vancouver Police report was written and did not have any information indicating the cause of death or suggesting possible foul play initially. Vancouver Police Department and CAIC have agreed to send all copies of law enforcement reports. The social worker has requested medical reports from local medical providers. There is one other child associated with the mother, a ten-year-old male, who continues to reside in the home. A social worker was assigned to work with the parents and school to stabilize the home, investigate allegations that the mother is abusing methamphetamine, and facilitate therapy for grief and loss for the ten-year-old and his parents.

On December 6, 2004, Children's Administration was informed that this child's death was caused by a kidney infection, and there were no indications of foul play. This death will be recorded as caused by natural causes. Law enforcement was involved in determining cause of death.

There were four referrals on this family. Three referrals were received because of a difficult pregnancy with an infant born with a severe congenital defect. The infant was hospitalized for a period of time and returned to the parents without the department's knowledge. Child Protective Services (CPS) investigated the first two referrals with maternity support services offered and declined. The infant died before a full investigation of the allegations could be completed. The mother was found to be using methamphetamine and was unable to care for her ten-year-old son. Services were offered to the family, and a dependency has been filed on the ten-year-old boy. The case remains open with on going services to the family. The ten-year-old boy is in out of home care.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-41
Region 6
Vancouver Office

Case Overview

This two-year-old Caucasian female died on December 12, 2004 due to head trauma received by hitting her head after being pushed by her mother's boyfriend. She was being cared for by her mother's boyfriend on Sunday, December 12, 2004. She sustained a blunt force trauma to her head. On Monday, her grandmother came to the home and found the mom passed out and this child dead. Law enforcement was called. Law enforcement responded and placed the mother's other two children with their biological father after a law enforcement records check came back negative. Law enforcement determined that he was stable and an appropriate caretaker for the children. They remain in his care at this writing.

Law enforcement believed at the time of the incident that this would be called a homicide caused by the mother's boyfriend. He allegedly is addicted to methamphetamine. It is unknown why the mother was passed out. Drug/alcohol addiction was suspected. The Vancouver office found out about this incident from an employee who is out stationed at the Child Abuse Intervention Center. This employee reported the four and six-year-old children were interviewed by law enforcement and the four-year-old disclosed walking in on the boyfriend giving mouth to mouth to the two-year-old in the garage on Sunday. He was also observed trying mouth to mouth in the bathroom a little later, witnessed by the same four-year-old. At this time, the boyfriend told the four-year-old to go out and shut the door. The boyfriend put the deceased child to bed and said nothing to the mother. The boyfriend was not arrested initially and law enforcement requested that Children's Administration not contact any parents until they contact law enforcement first.

The mother chose to ignore risks to her children such as the unexplained bruises on her four-year-old, a cigarette burn on the four-year-old and the decedent, drug use by the boyfriend, leaving her children with the boyfriend and a man whom she described as his "supplier" whom she reported having "bad feelings" about. The supplier had contact with the boyfriend upon his release from jail in order to have "closure" in regards to their relationship. Though the child was ill in the week before her death, the mother reported that she did not physically check on her between 10:00 p.m. and 10:00 a.m. at which time the child was found deceased.

Allegations of physical abuse, negligent treatment, and maltreatment in regards to the boyfriend are founded. The act of pushing a child backwards which caused her to strike her head on a wooden post causing internal bleeding in her brain is physical abuse. The boyfriend chose to use illegal substances while providing care for three minor children and failing to seek medical attention for that initial injury. After determining that the child was dead, the boyfriend placed her in bed where she remained for 14 plus hours until her body was discovered. Law enforcement investigated, and arrested the boyfriend for homicide.

The 15 referrals received prior to the death of this child were a combination of referrals received when the mother was a child herself as well as a parent. Eleven of the 15 referrals are in reference to the mother as a child within her parents' home. Two of the 15 referrals were on the

mother as a parent, and they were screened as information only. There was one referral on the boyfriend, and it was screened information only. Prior to the death of this child, there were no services provided to this family as there were no accepted CPS referrals. The mother reported having counseling as a minor and was involved with Family Reconciliation Services (FRS). The mother was offered counseling to deal with her grief, however, she reported that she already has access to counseling. The boyfriend received no CPS intervention prior to his arrest in the death of this child.

Mental health, child care, and counseling were offered and provided to the biological father of the decedent's step-brother and step-sister after their sister's death. Substance abuse treatment and Intensive Family Preservation Services (IFPS)/FPS were offered and refused.

The step-father received no CPS intervention prior to this child's death. After this child was murdered, he agreed to a safety/service plan and followed through on each aspect. At the last contact, he had been granted temporary custody of his biological children, had documented his compliance with his substance abuse treatment, had the children in school/day care five days a week, had counseling arranged for both his children to begin within a couple of weeks and was working with a Family Court guardian ad litem (GAL) to determine what was in the best interest of the children.

Issues and Recommendations

I. Policy Issue

A. Issue: The day care failed to report bruising or a fat lip on the child.

Recommendation: Social worker made a referral to intake on the failure to report suspected abuse and neglect on the part of the day care.

Child Fatality Review #04-42
Region 6
Tumwater Office

Case Overview

This 17-year-old Caucasian female died on May 23, 2004 due to injuries from a motor vehicle collision on May 9, 2004. She was in a coma until she passed away on May 23, 2004 at Harborview Medical Center. Law enforcement states the collision was due to excessive speed. They indicated that drugs or alcohol were not believed to have been involved.

This family first came to the attention of the department in September 1995 after a third party referral was received. In November 1995, a second referral was received on this family alleging physical abuse by the parents towards the decedent. An investigation was conducted. Family Reconciliation Services (FRS) were offered and refused by the parents.

On October 16, 2003, a third referral was received regarding the decedent. She indicated that her father had slapped her. Law enforcement responded and spoke with the child. Law enforcement went to the home and spoke with the parents. The deputy suggested they look into filing an At Risk Youth petition and seek other means to discipline their daughter. This referral was tagged information only.

On May 23, 2004, a fourth referral was received regarding the decedent. She had been in a motor vehicle collision on May 9, 2004 and had been in a coma since that time. She died as a result of her injuries sustained in the collision. Speed was a factor, but it is believed that alcohol or drugs were not. This referral was screened out.

The decedent has two adult siblings who were not residing in the home at the time of the collision.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-43

Region 6
Vancouver Office

Case Overview

This two-month-old Caucasian male died of mechanical asphyxia on March 23, 2004 according to the Clark County Medical Examiner's office. The newspaper reports the child had been sleeping in bed with both parents and death was ruled as accidental. This child has two siblings, a female, age five and a male, age three.

This family had three prior referrals alleging physical neglect and maltreatment. The first referral was referred to the Alternative Response System (ARS) and services were offered to this family, but refused. The second referral was an information only referral.

The Department received the third referral on March 18, 2004 alleging concern about the condition of the home with regard to disarray of the home, dirty dishes, and dog urine on the rug. An additional concern was the practice of placing the infant to sleep on his stomach on what the referrer believed was a waterbed. An additional concern was that the younger children (half-siblings of the infant on the father's side) had been observed to be playing in the living room without direct adult supervision while the mother was asleep, and the father was outside. Before the social worker received the first referral, the infant was found dead in his parents' bed of what was ruled "mechanical asphyxia." The social worker observed the other two children, spoke with mother, extended family on both sides, the pediatrician, law enforcement, the medical examiner. No other health or safety issues were noted.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #04-44
Region 5
Tacoma Office

Case Overview

This 13-year-old female Asian American child died from anoxic encephalopathy resulting from Diabetic Ketoacidosis on February 22, 2004.

Needing to leave the state to attend training, the biological father left his daughters ages 13, 11, and ten with their non-custodial mother. The non-custodial mother has custody of one daughter, age seven, and has a four-year-old son also living in her home. The boy is a half-sibling to the girls. While staying with her mother, the decedent and others at the home became ill.

The father picked up his daughters on Friday, February 20, 2004 and returned home to Thurston County. At that time, the decedent was described as doing well. The following morning she was not feeling well and had difficulty breathing. She used her inhaler and laid down. When she got up, her father tested her blood sugar level and became concerned. She was given an insulin injection. Shortly after, an ex-stepmother arrived, and the decision was made to take her to the Good Samaritan Hospital in Puyallup.

During the transport she stopped breathing, and the ex-stepmother stopped the car, began cardiopulmonary resuscitation (CPR), and 911 was called. Paramedics responded and transported her to Mary Bridge Hospital where she was admitted to the Intensive Care Unit (ICU). She died a day later from anoxic encephalopathy resulting from Diabetic Ketoacidosis.

The initial CPS report had stated that the precipitating medical emergency occurred while the child was in her non-custodial parent's care. This appears not to be true as noted above. It was also suggested that neglect on the part of both the custodial and non-custodial parent may have played a role in the child's death. This too appears to be unsupported.

The cause of death was determined by the Pierce County Medical Examiner to be related to Diabetic Ketoacidosis, and the manner of death as natural. Both the medical examiner and the attending physician concluded the death was not suspicious for child abuse or neglect.

The earliest referrals regarding this family indicated concerns for neglect of the children by the biological mother who remained the primary caretaker, as the parents appear to have had multiple periods of separation (1993-1997). Many of the investigations resulted in findings of "founded" for neglect by the mother, but did not result in any out-of-home placements of the children.

Numerous medical professionals frequently reported that the mother was failing to meet the medical needs of her diabetic daughter, the decedent, as well as concerns for physical neglect of all the children in the home (e.g., not meeting basic needs; inadequate supervision). There were additional concerns for the mother's drug use/drug selling, mental and physical health problems, criminal and assaultive behavior.

Referrals regarding the mother's physical and medical neglect continued, and the father filed for divorce and sought custody of his two oldest children. In 1997, a homebuilder intervention was initiated by CPS and file documentation suggests that the services were not successful. The father appears to have taken custody of his two oldest daughters by early 1998, and the younger two children stayed for a time with the maternal grandparents, eventually going to stay with their father and stepmother temporarily.

The two youngest children returned to the care of their mother in 1998. However, the deceased child and her 11-year-old sister appear to have remained in the care and custody of their father since 1998, and were not involved with the last five referrals (1998-2002) relating to the mother. There were no reported concerns for the children while in their father's care and custody.

The mother had a child with another man in late 1999. In July of 2002, the mother engaged law enforcement in a "hot pursuit" situation with her two youngest children in the car. By this time the father had taken custody of his third daughter. CPS involvement ended in January 2003, remaining on inactive status under the supervisor until administratively being closed in June of 2003.

In late February 2004, CPS received information that the 13-year-old had died. Initially, information received by CPS intake indicated that the child had experienced her medical emergency while in the care of her mother, the non-custodial parent, that suggested possible neglect resulting in the death. Information collected post-fatality indicated that the death was not suspicious or related to child abuse or neglect. A CPS investigation was conducted on the father in Region 6 while Region 5 conducted a CPS investigation on the biological mother regarding concerns not related to the fatality, but for concerns of neglect to her two other children. The findings were unfounded for both investigations.

All noted services involved the mother, who had not been the custodial parent of the deceased child for several years. As the custodial parent (father) had never been involved with Children's Administration prior to the fatality incident, no service history exists. Mental health, medical services, public health, and Intensive Family Preservation Services (IFPS) were offered and accepted by the mother. Substance abuse services were refused by the mother.

The father had never been previously identified as a subject of abuse or neglect, and the deceased child had been in his care for several years prior to the fatality. However, the non-custodial mother had had an open case with CPS within the year prior to the fatality. While that investigation had no involvement with the deceased child, Children's Administration services had technically been offered to the family within the year prior to the fatality incident, Region 5 was directed to conduct a Child Fatality Review.

As previously noted, concerns for child abuse and neglect regarding the mother's care of her children have spanned 11 years. During that time, there were 20 referrals. Due to multiple referrals on several single incidents, the number of actual incidents is closer to 15.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Information used in this report derived from reviews done in both Regions 5 and 6. Issues involving deficits in social work and supervisory practice were noted during both reviews for the most recent CPS investigation of the non-custodial parent which did not involve the deceased child. None of the practice deficits noted appeared relevant to the fatality review, and did not involve any current social worker or supervisor.

Child Fatality Review #04-45
Region 1
Spokane Office

Case Overview

This 16-year-old Native American male died on September 29, 2004 due to a gun shot to the face. He was shot in the face by an adult son of his guardian. The adult son reported that the firearm unexpectedly discharged. The cause of death has been determined accidental.

This child was shot and died in a Spokane Tribal licensed foster home. The foster mother had left the children in the home with a caretaker not approved for supervision of the children.

The Spokane Tribal licensor, as well as a Tribal Child Protective Services (CPS) social worker, addressed supervision concerns with the foster mother prior to and including in August 2004. In September 2004, the licensed foster parent for the decedent had left him, his sibling, and another child in the care of her son. The foster mother had previously been told to report to her Tribal licensor when she would be out of town and approved care for the children would be sought. She did not notify Tribal Services or the licensor that she was out of state. The son of the foster mother was not an approved adult to provide care and supervision to children. He had a felony conviction. On September 29, 2004, he shot the decedent in the head with a .22 caliber handgun.

The foster mother received the following trainings as part of her foster home licensure: Foster Care Pre-Service, child development education, First Aid, HIV/AIDS, 16 hours of child abuse and neglect training, blood borne pathogens, and attachment and bonding training.

The decedent was born on February 16, 1988. His mother had an extensive substance abuse history, and the decedent was placed with his maternal grandparents on August 1, 1991. This child never returned to his mother's care. On June 13, 1997, he was placed with the foster mother through the Spokane Tribe in Wellpinit, Washington. He eventually entered into a guardianship while in this home. His biological mother and father had not had any contact with him while he was in placement.

An application for foster home licensing was submitted by the foster mother on August 30, 1995. A home study was completed on September 6, 1995. During October of 1995, a provisional license was granted to her. The provision was that her children would not be alone with any foster children, and she was expected to re-evaluate if substance abuse was an issue with her children. She received her foster care license on April 18, 1996. In 1997, attempts to meet with the foster mother in the foster home were resisted by her. She would cancel the scheduled appointments or refuse to allow licensors into her home. Each time the foster home was to have the foster care license renewed she would avoid the scheduled appointments at the home. This continued to be a theme through 1998, 1999, and 2000.

On May 4, 2003, she was interviewed and counseled that she is required to report to her licensor when she will be out of town and confirm what arrangements she has made for care and supervision of the foster children. On April 22, 2004, the Tribal licensor made a visit to assess

the new home when the foster mother moved. She had moved with no notice to her licensor. At the April 22, 2004 home visit, the foster mother indicated there were no weapons in her home. In July 2004, the licensor and Tribal social worker met with her due to concerns for a teenager residing in the home. The concern was suicidal behavior by the teen. Services were offered to that teen. On September 29, 2004, the foster mother was away from home when the decedent was shot in the face by the foster mother's adult son. No referrals were received regarding this licensed foster home until the date of this child's death. The license for this foster home was revoked as a result of this child's death.

Issues and Recommendations

I. System Issue

A. Issue: The Spokane Tribe does not have an automated system to record and retain information related to child abuse and neglect as well as licensing information which has been a barrier to the accessibility of accurate historical information regarding children, families, and foster homes.

Recommendation: The fatality review committee recommends that the Spokane Tribe have access to the state's Case and Management Information System (CAMIS). This would assist with mutual access and sharing of information regarding children, families, and foster homes by both the state and the Spokane Tribe.

B. Issue: Members of the Spokane Tribe that participated in this fatality review identified a need for an alternate care or respite care system for Tribal foster homes.

Recommendation: The Spokane Tribe can utilize their regional licensor to assist with the development and implementation of a respite care model.

C. Issue: Members of the Spokane Tribe that participated in this fatality review identified a need for protocol and resources to address critical incident debriefing for Tribal staff and community, as well as resources for addressing secondary trauma that social service employees may experience during traumatic events.

Recommendation: The Spokane Tribe can utilize their regional licensor to assist with the development of a protocol and identification of potential resources for critical incident debriefings as well as addressing secondary trauma issues with employees.

D. Issue: The fatality review participants identified the value of collaboration between Children's Administration and the Spokane Tribe in joint child fatality reviews, with co-facilitation and clear process.

Recommendation: Inclusion in the Regional 7.01 plan.

II. Policy Issue

A. Issue: Although WAC 388-148-0190 addresses the safekeeping of firearms in a licensed foster home, there is no specific signed policy statement regarding firearms within Children's Administration or the Spokane Tribe as a child placing agency.

Recommendation: *The Spokane Tribe would like to utilize a firearms policy with their tribal foster homes. Children's Administration has drafted a statement that is being reviewed by Licensed Resources to use with all licensed foster homes.*

Child Fatality Review #04-47
Region 6
Centralia Office

Case Overview

This 15-year-old Hispanic female died on April 6, 2004 due to suicide. The mother reported to the mental health worker, that on the morning of April 6th her daughter was acting "funny" so she brought her to the local emergency room. Due to the child's prior suicide attempt, the hospital gave the child activated charcoal. The mother reports the child had a seizure and died. Prior to bringing her to the hospital the mother reports that her daughter denied taking any pills or attempting to overdose.

A referral was received on September 9, 2003 requesting Family Reconciliation Services (FRS). The referral indicated the mother wanted to find out how her 17-year-old son could emancipate. FRS concluded on November 18, 2003 with the family stable. The father was preparing to be deployed to Iraq. The decedent was not running away from home with her brother anymore, the brother was on probation for a theft charge, and the mother was applying for her citizenship.

On December 19, 2003, a referral was received for Child Protective Services (CPS) services. The decedent was due to be released from Fairfax Hospital after an apparent suicide attempt by overdosing on pills and alcohol. The suicide attempt was prompted by the child's disclosure of sexual abuse by her brother. The brother was out of the home in detention on unrelated charges. Initial contact with the parents was on December 19, 2003 by Intake for further information. The social worker requested an initial face-to-face extension since the perpetrator was in detention and the child was referred to Cascade Mental Health (local mental health agency) to address the abuse and suicide attempt. An extension was granted until January 15, 2004. The mother was contacted on January 14, 2004 after local law enforcement was contacted repeatedly to assist in the interviews. The son was incarcerated at Maple Lane School until he is 18-years-old for vehicle theft.

The mother reported that one day in December 2003 she left for work, came home and found her daughter drunk with her wrists slashed. This child was transported to Fairfax and was released on December 22, 2003. The mother stated the sexual abuse between the siblings occurred years prior when this child was nine and her brother was 12. According to the social worker the mother seemed to minimize the sexual abuse. At the time of the interview, the decedent had been to the mental health center two times and her medications were being monitored by several doctors. The child was reportedly taking Prozac. The mother reported quitting her job following the incident to supervise her child more closely. A child victim interview was conducted on January 15, 2004. The child was interviewed by a detective and the social worker. The child became very tearful in talking about sexual abuse so the interview was concluded. The child confirmed that when she told her mother and step-father about the sexual abuse, her step-father said that her brother would not be allowed to return to the home. The child reported feeling some shame with her mother's attitude of "why didn't you tell him to stop." The child confirmed that she was involved in counseling at the mental health center with a therapist.

The safety assessment was completed on February 20, 2004. The FRS case was reviewed for closure on the son since he was on probation and then placed in Maple Lane. The initial risk assessment was completed on March 15, 2004. The child was still attending the mental health center but specifics of therapy were not released due to a lack of an updated release of information. On April 5, 2004, the social worker prepared the case for closure. The brother was due to be released in June from Maple Lane. He still had the pending case of the sexual abuse of his sister against him. The mother was conflicted and talked about sending the child back to family in Panama. The social worker urged the mother to continue taking the decedent to counseling even though the child was refusing continued counseling. The family was given crisis numbers in case of any emergencies. The allegations of physical neglect: lack of supervision was unfounded. The safety net was that the child was regularly attending school, and urged to continue with counseling. Maple Lane School was aware of the victim in the home and was to call CPS if the brother was released to the home.

The case was closed to CPS on April 8, 2004. The social worker was notified that the child died on April 6, 2004.

Issues and Recommendations

I. Quality Social Work

A. The assigned social worker went out to the mother's home upon learning of the child's death with the mental health provider; the case was not active at the time of the death.

Recommendations: *The social worker should be commended for going above and beyond the call of duty at the time of the child's death.*

No issues or recommendations were identified by the review team.

Child Fatality Review #04-48
Region 3
Lynnwood Office

Case Overview

This two-month-old Caucasian male died from Sudden Infant Death Syndrome (SIDS) on July 3, 2004. The infant was found by his mother cold and unresponsive about 9:00 a.m. His head was turned to the side, and it appeared some blood had come from his nose. The mother had last fed him at 5:00 a.m. He appeared fine at that time and went back to sleep on his back on the bed next to the mother. He was not near a pillow and had nothing near his face according to mother. She said she heard no sounds of distress. The mother immediately called the aid car.

The Snohomish County Medical Examiner was called to the scene by the police. The father, who was in substance abuse rehabilitation, was called to the home to be with the mother. There is history with the department within twelve months of the child's death. The mother was a victim of severe abuse by her parents.

Central Intake received a referral and sent a social worker to meet with the family. A decision was made to leave the other children in the home with a safety plan. The parents were cooperative with the social worker's suggestions as to services. The family had sufficient funds to access services themselves. The mother had been seeing a therapist for some time and was on anti-depressants.

There is extensive documentation of history of child abuse/neglect to the mother as a child. In 1993, the mother was in foster care for some time after allegations that her mother, who was diagnosed as having Multiple Personality Disorder, had abused her physically, sexually, and emotionally. The same diagnosis was applied to her daughter, the mother of the decedent. It is unknown how much of this actually occurred, as the psychologist who was treating the mother's mother (and later the mother) was later discredited in his work with this family by an independent review by another psychologist. His diagnoses in this case were determined to be unreliable, at best.

In 1996, mother gave birth to her first child. Little is known by the Department about her first child's father, or the mother's relationship with him. The mother later married a different individual and they had twin boys in 2000. It was after this, in August of 2003, that the Department received its first referral on the mother as a parent. When this referral came in, there was no connection made between the mother and her history as a child. The referral alleged the mother got drunk frequently, and the mother and father recently had an argument and the mother "got violent" and "punched at the wall, leaving two holes in it." The referrer said the father had expressed to her that they both needed to go into alcohol treatment. In the investigation, the social worker determined it was more likely than not that child abuse/neglect did not occur, and she closed the case as unfounded. The parents had minimized and denied much of the information, and there was nothing to refute that denial. There was some information gathered during the investigation that the parents had been arguing about the mother's affections for another man who had been staying in the home.

On July 3, 2004, the Department received word from the Medical Examiner's office that a two-month-old boy since born to mother, had died in the home in circumstances much like SIDS. At the time this referral came in, the connection was made between the mother and her previous history as a child in 1993. As not all of the circumstances of that past case were known immediately, the mother's history was treated as a serious risk factor. The investigation proceeded accordingly with strict safety and service plans until the Department could get a clearer picture of the mother's mental stability. In the investigation, it was learned the father had gone to inpatient treatment, as his alcohol use was escalating. He was there at the time of the death. It appeared as though the parents had been separated prior to that. The father stated that his wife had DNA tests done after the birth of the decedent, and it was determined that he was not the biological father, but the man who had been staying with them in the family home and having a relationship with the mother was the father. It was also learned that the mother provided the family income through a lifetime trust left by her grandparent.

After conversation with the mother's current therapist, a reading of reports on the past abuse by her mother and her completion of a substance abuse evaluation that determined she was not dependent, it was determined that the mother would not present an undue risk. The referral was closed as unfounded after receipt back of the toxicology results from the infant's autopsy showing nothing of concern. This was considered a SIDS death.

Issues and Recommendations

I. Practice Issue

A. Issue: The first referral in 2003 failed to connect the current family with significant history available in CAMIS on the mother as a child.

Recommendation: Follow policy for thorough search for history at intake.

B. Issue: The first referral clearly alleged alcohol abuse by the mother that was connected to the alleged child abuse/neglect. The closing risk assessment, however, documented that it was "not probable that the use of alcohol or a controlled substance is a contributing factor to the alleged abuse or neglect." Instead of referring the mother for a chemical dependency assessment based on the allegations of alcohol abuse, the social worker asked her to do a urinalysis for illegal substances.

Recommendation: *Follow policy for referring parents for a chemical dependency assessment when there is an indication that substance abuse is a contributing factor to the abuse or neglect.*

II. Quality Social Work

A. In the second referral, reporting the SIDS death of the infant, the investigating social worker went to exceptional lengths in gathering information from many sources to allow her to make a determination that the Department could safely leave this family to their own resources.

Child Fatality Review #04-49
Region 3
Sky Valley Office

Case Overview

This five-year-old Caucasian male was shot to death by his grandfather in front of the Monroe City Hall on August 5, 2004. The grandfather brought his grandson in the car to the area of the Monroe City Hall at 6:30 in the evening. He took his grandson out of the car and walked toward the building where he then shot the child in the head, killing him. He then fatally shot himself. He left a suicide note stating that he did not want to leave the burden of caring for his grandson to his wife.

It was apparent at the scene and from the note left by the grandfather that he shot the grandson. It was determined there was no reason for a Child Protective Services (CPS) investigation and a finding as the grandfather was also deceased, and there are no other children.

The grandmother and grandfather had been married for 38 years. They lived in Texas until just a few months prior to this incident. After seven years of trying to have children of their own, they had adopted two children, a boy and a girl. The boy, an infant, had mental health problems from his childhood. He was hospitalized and diagnosed with mental illness, in particular bi-polar disorder. There were difficulties throughout his childhood and youth. His parents sought and received services for him from several agencies. He remained troubled.

In 1999, their adopted son had a baby. Because of mental health difficulties, their adopted son was unable to care for his baby. When the baby was almost a year old, the grandparents were awarded custody of him through the family court system in Texas. As a preschooler, he was diagnosed with bipolar disorder and attention-deficit (hyperactivity) disorder. He began therapy, psychotropic medication, and other services early in his life. He was in a special class in the public school in Dallas.

In 2003, the grandfather lost his job with an insurance company. He had always been plagued by depression (he was hospitalized for depression and suicidal ideation a total of eight times in his life). The depression intensified after his job loss. After a year of unemployment, severe depression, coping with his grandson and his difficulties, and exhausting their financial resources, the family moved to Monroe where their grown daughter, her husband, and two young girls were living. The grandfather's condition deteriorated after the move. He was hospitalized for very severe depression for a day or two, but was released.

The grandson had no services initially in Monroe. It was summer, and there was no summer school in Monroe for children with his needs. The grandmother started pursuing other avenues for services for him, but had limited success. Most of the services were in King County. At this point, she began working with a mental health agency and Children's Administration. During this time, the grandmother's health was failing. She was having a relapse of her Multiple Sclerosis. She needed day care for her grandson, but once he began to attend a day care program, the day care refused to have him back without a full time aide. The grandmother, the

mental health agency, and the Sky Valley Children's Administration office were all working toward a goal of locating and resourcing an aide for the grandson when the grandfather began to act out a suicide plan.

While the grandmother was out signing some medical forms on August 5, the grandfather took his grandson and drove to Mukilteo. There he purchased a handgun and drove to the Monroe Police Department, arriving there about 6:30 p.m. He took his grandson out of the car, walked with him up to the front of the station and shot his grandson and then himself in the head. The grandfather left a suicide note explaining that he did not want his wife to have the burden of caring for the grandson alone.

A mental health agency had also been working with this family, and alerted Children's Administration to their plight. On July 22, 2004, a Child Welfare Services (CWS) intake referral was called in by the mental health agency therapist who had been working with the family to access services for their grandchild. It was hoped that with both agencies working together, a more comprehensive service plan could be delivered.

Their planned services for the family were respite care two times a month, and some hours of services by an Individual Treatment Aide to assist in the supervision of the grandson. The Sky Valley office was in the process of working out hours for Medicaid Personal Care plan to provide funds to pay for an aide to accompany the grandson to the daycare.

At the time of the incident, the grandmother and grandfather were in contact with a private adoption agency with the idea of finding a home into which the grandmother hoped to "slowly transition" the grandson. They still wanted to be able to visit with him after he had been moved into an adoptive home. The grandparents were adamant that they did not want to place the grandson until/unless this could happen.

The grandmother in this case was actively working with Antioch, a private adoption agency, to locate a family willing to enter into an open adoption agreement for the child. The grandmother was clear that she was not willing to accept any other type of placement. The grandmother had very definite ideas about how the transition from her home to the adoptive home would proceed once a home was located. Until then, the grandmother wanted a day treatment program for the child. As this was not available in this area, the Department was working to set up a day care program that included a one-on-one aide, as the child could not be served in a day care without one. Compass Mental Health was working with the family to set up respite and to have an individual treatment aide (ITA) in the family home. After the death, when the case was being staffed at the Snohomish County Child Death Review, a representative from Compass Mental Health presented what the involvement had been from that agency. It was stressed that although a voluntary foster care placement had been suggested for the child, the grandparents had not been willing to consider it.

Issues and Recommendations

I. Practice Issue

A. Issue: Although this referral was initially taken on July 22, 2004, it was not assigned to a worker until July 30th. No activity was documented until the conversation with the mental health worker on August 2, 2004. It was apparent from information gathered during the review, however, that there was collaboration with the family well before that.

Recommendation: Follow policy regarding appropriate and timely documentation of case activity.

Child Fatality Review #04-50
Region 3
Bellingham Office

Case Overview

On February 23, 2004, this 11-month-old Caucasian female was found deceased by asphyxiation. A Bellingham Police Detective called the Bellingham Division of Children and Family Services (DCFS) office at 1:15 p.m. on February 23, 2004 to report the death of this child. The detective stated that her death appeared to be accidental at that time, and an autopsy would be done to determine the cause of death. He stated that she was put down for the night swaddled in a sleeping bag on a couch which was her normal place to sleep. She was found dead on the morning of February 23, 2004.

On February 24, 2004, an autopsy was performed, and it was determined that she had died of asphyxiation. She had a piece of carrot lodged in her throat which caused her death.

On March 12, 2004, the medical examiner contacted the assigned Child Protective Services (CPS) worker to inform him that the lab results have returned from the autopsy, and the child was found to have methadone in her system. The sibling of the deceased child was then placed into protective custody and Shelter Care was established on March 16, 2004. This child remains in foster care.

The allegation of neglect in the original referral regarding her death was due to the sudden circumstances of the death, and an investigation would generally be done in those circumstances. However, when it was discovered that the death was due to asphyxiation by a piece of carrot lodged in her throat, and then later that she had methadone in her system at the time of her death, it was apparent that some degree of neglect was involved. According to the medical examiner, the level of methadone in her system was likely from oral ingestion and may have been relevant to the child's death. The methadone may have affected her ability to cough up the carrot lodged in her throat.

In addition to these referrals, there were prior referrals on each of the parents as children. For the mother, these CPS and Family Reconciliation Services (FRS) referrals date from December of 2000 through April of 2002. They are primarily concerned with drug/alcohol use and the consequent neglect by the grandmother when the mother was a child. The record also gives some indication that the mother may have been learning disabled and may have had a problem with depression and anger, particularly as a youth. During the mother’s childhood, her mother allegedly had to leave the family home due to her and her brother's "violent, uncontrolled" outbursts at their mother. As a teen, the mother allegedly "beat her mother to the point of injury," according to the Alternative Residential Placement (ARP) petition filed by the mother's father. There were evidently numerous instances of legal contempt motions against the mother on the ARP order when she was a youth.

Regarding the father's history with the Department, five CPS and FRS referrals were received regarding difficulties in his family of origin. They date from 1994 to 2000. They indicate there may have been problems with maternal drug use.

After the parents of the decedent were married in August of 2002, four CPS referrals were received in 2003 concerning their children. The first of these was a report by a medical professional in January. The referrer was concerned about the 16-year-old mother and her six-month-old son. The six-month-old was described as a "micro preemie," very small at birth, who needed regular injections as a preventive measure due to infection risks. He had not been getting these. The referrer also said the mother was pregnant and due in May and was behind in her prenatal visits. When the social worker went to the home, the parents appeared appropriate with the baby and offered medical information. The parents followed through with medical care. The social worker identified an issue with the father's drug use. He had a chemical dependency assessment and as of April of 2003 had been to some treatment meetings for marijuana use, but missed enough meetings that he was starting over. By this time, the decedent had been born (April 15, 2003). The baby looked fine at a home visit on April 21, 2003.

The case was closed in July. The father failed to complete treatment. The doctor's office stated the children looked good with no medical problems/issues at that time. The parents had family support, and there was no apparent child abuse/neglect.

On August 10, 2003, CPS received another referral. This was from a close family relative who stated that friends and relatives had been calling her about the parents' reported drug use and neglect of the children. She said they were smoking crank and crack daily, and the infant was not being held, but instead put in crib with a propped bottle. The referrer also stated the parents stayed up using drugs for three days at a time, then slept all day. This referral was screened out on the basis that there were no specific observations of drug behavior or equipment in the home, and a recent investigation showed the parents were following through with medical appointments, and the children were observed to be in good health.

A third referral was received on August 25, 2003 from an extended family member. The allegation was that the family lived in a "crack house" and the police were at the home on a "near daily basis." He stated that the oldest child was kept in a high chair for an excessive amount of time while the parents used drugs. The referrer characterized the father as "very violent" and stated that he was having sex with a 14-year-old girl. This referral was screened as information only by the Central Intake office, and this screening decision was not changed when it arrived at the Bellingham office.

The fourth report received by CPS prior to the death of this child was on December 23, 2003. Again, the information came from an extended family member. The allegations were that the mother had been arrested over that weekend for assaulting the father. The children were in the home at the time. It is unknown if they witnessed the assault. The referrer went on to state the mother often "takes off" leaving the children in the care of the father, who in turn leaves the children in the care of an 18-year-old paternal uncle. The referrer alleges that neither the father nor the uncle are appropriate care givers because of ongoing drug use. The referrer had "heard" that the parents leave the children in chairs and in bed for extended periods of time.

This referral was assigned a risk level of two by Bellingham intake staff, and was referred to a contracted provider for Alternative Response Services (ARS). Documentation indicates the risk was established at this level because there was no indication that the children had actually witnessed the reported incident of domestic violence, but it was felt the apparently chaotic environment of the home may have a negative impact on the development of the children.

A letter was then sent to the family, with a copy to the agency that was contracted to do ARS in the Bellingham area. This letter advised the family they had been referred to CPS, but because the concerns reported were lower level, the issue had been referred to a private agency that would talk with them about the concerns and offer services. The CPS case was closed at that point.

The contracted ARS provider attempted to contact the family and offer services. They made a phone call to the family on December 26, 2003. They made two more calls before they spoke with the mother on February 17, 2004 and offered services, which she declined. The ARS case was then closed by the agency. There was no documentation of further contact from any social service agency until CPS was notified of the child's death on February 23, 2004.

It was later learned (post fatality) that the parents separated after that incident of domestic violence, with the father moving out of the home. From then until the death of this child, the mother lived in the home with the children and reportedly had several guests during that time. Both parents and all connected to the case denied any knowledge of methadone being in the home, and neither could offer any ideas on how the decedent may have consumed it.

Issues and Recommendations

I. Practice Issue

A. Issue: The referral on January 8, 2003 came into CPS from a home nurse, and alleged that the parents of the six-month-old were not following through with preventive injections necessary due to the child's extreme prematurity. It was originally designated a risk level of five but was reduced to two, and therefore a low risk standard of investigation, by the supervisor on the grounds that the nurse was already involved. This decision, made without consultation, was in error particularly given the risk factors involved.

Recommendation: Follow policy on screening decisions where there are allegations of abuse and neglect.

B. Issue: A referral was received from Central Intake on August 10, 2003 and was screened in for investigation with a risk level of five. The allegations from a close family member concerned very young parents being "high" on drugs and neglecting their two small children. The supervisor changed that decision and screened the referral out on the basis that the referrer had not directly observed this. There was sufficient information given in the referral that collateral contacts would have revealed the severity of the situation, had they been contacted.

Recommendation: Follow policy on screening decisions where there are allegations of abuse and neglect.

C. Issue: When the referral came in on August 25, 2003 from Central Intake to Bellingham, it was screened out for investigation. There was an allegation of ongoing drug abuse and consequent neglect of two small children. Given the history and other risk factors, this referral should have been marked for investigation. Also contained in it was an allegation of sexual abuse by an adult male to an unknown 14-year-old girl. Computer documentation shows that when the screened out referral reached the office, the supervisor sent this referral to the wrong law enforcement jurisdiction.

Recommendation: Follow policy on screening decisions where there are allegations of abuse and neglect. Send law enforcement reports to the jurisdiction in which the alleged incident occurred.

D. Issue: A referral was received on December 22, 2003 in the Bellingham office. The referrer, a family member, shared information about the mother being arrested over the previous weekend for a domestic violence incident against her husband. The children were in the home at the time of the incident and the referrer did not know what they actually observed. The referrer also stated the mother had a habit of leaving the children in the care of the father, who then left them with his 18-year-old brother who the referrer said was not capable because both the father and his brother were heavy drug users. She also stated her belief that the mother was developmentally delayed or had mental health issues, and that both parents used methamphetamine.

This referral was screened as ARS and sent to a contracted provider. The contracted provider made three phone calls to the mother from December 26, 2003 to February 17, 2004. When the provider finally spoke with the mother and offered services, the mother declined, saying her problems were all solved by that time.

Recommendation: Follow policy on screening decisions where there are allegations of abuse/neglect. This referral should have screened in as a high standard of investigation considering the history and risk factors associated with the family.

The contracted provider should have made more concentrated attempts to reach the family and then to engage them once reached. A home visit may have produced more results in this area.

Action: Following policy on screening decisions was addressed by the region through personnel action.

II. Quality Social Work

A. Despite being assigned the first referral as a low risk response, the assigned social worker assessed that the risk was greater than that, and treated the referral accordingly. She made more than one visit to the family, offered services, and made several collateral contacts.

Child Fatality Review #04-51 and #04-52
Region 5
Bremerton Office

Case Overview

These six week and 16-month-old Native American males were found deceased on November 14, 2004 due to malnutrition and dehydration.

On November 14, 2004, shortly before 3:00 p.m., the Kent Police responded to a welfare request from the mother's boyfriend. He had been released from jail that morning and allegedly had been trying to contact the mother by phone the past ten days. He had gone to the apartment, heard his two-year-old son, but could not get anyone to open the door. He then contacted law enforcement who gained entry to the residence where they found his naked and dirty child. The home smelled strongly of urine and feces. A search of the residence found the 16-month-old brother lying on his stomach deceased. In the master bedroom officers found the six-week-old newborn in a bassinet covered with a blanket. The child was emaciated and deceased. The mother was found in the bed with covers over her head. The room was dark with a television on, and the floor was covered with dirty clothing, garbage, and empty beer cans. The strong odor along with the empty containers suggested the mother may have passed out due to intoxication. The mother was taken into custody.

The cause of death for both children was determined by the King County Medical Examiner to be from malnutrition and dehydration.

The surviving sibling was removed from the home and placed with relatives. Prior to involvement with Child Protective Services (CPS), the mother had been involved with chemical dependency treatment, Alcoholics Anonymous, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and community domestic violence advocacy. Additionally, the mother received services through the local Department of Social and Health Services (DSHS) Community Services Office (CSO) prior to CPS involvement, continuing until the child fatalities occurred. CSO services included referrals for Maternity Support Services, Pregnancy to Employment , and Alcohol and Drug Abuse Treatment and Support Act (ADATSA) assessments. After moving to King County in May of 2005, this family received Public Health Nurse (PHN) services through the King County Health Department as well as WIC services. The first referral to CPS regarding the mother was made on February 20, 2001. She had entered in-patient alcohol treatment and disclosed to a counselor that there had been loaded guns in her and her husband's bedroom. The information was that the guns had safety locks on them, thus the report was taken as information only.

On September 10, 2002, CPS received a report from a concerned hospital social worker. The mother had been admitted to the hospital allegedly due to a binge drinking episode, and soon after discharge the mother returned to the hospital claiming she was hearing voices telling her to

kill herself. The referral alleged that her then five-month-old child was being cared for by a friend with a developmentally delayed daughter who might pose a risk to the child and the sibling. The referral was assigned to the Alternative Response System (ARS) and engagement was initiated by the Kitsap County Health District. Several days later another report was made indicating that the mother was planning to resume care of her child while expressing trepidation regarding hurting herself. This referral was sent to the ARS provider who reportedly had already initiated engagement with the family. The ARS worker's documentation indicated the apartment and mother and child were clean and neat. The child was described as healthy, alert, and happy. The mother indicated a willingness to have the worker back to the home and was open to receiving services. In mid-December 2002, the ARS services were terminated with "all services completed."

In late January 2003, the Bremerton DSHS CSO sent a First Steps referral to Kitsap Health District for Maternity Support Services, noting the mother's pregnancy. In July 2003, the 16-month-old was born with the mother's boyfriend listed as the father. In September 2003, the mother applied at the CSO for an ADATSA assessment and a referral was made. There is no indication that the mother followed through with ADATSA.

CPS intake was contacted on October 8, 2003 after the great-grandmother reported having gone to the home and found the mother "staggering around the house" and the two boys filthy (feces and urine soaked) and unfed. The assigned CPS social worker conducted a home visit, and the situation assessed was found to not be substantively concerning. The home was tidy and in order, food was available, and the care of the children appeared adequate. A signed written service agreement was obtained by the worker, which included a condition that the mother obtain a drug/alcohol assessment. In November 2003, the mother was assessed and found to meet the criteria for alcohol dependent. She was deemed amenable to treatment, and the recommendation was for a six month relapse prevention program. The case was closed December 16, 2003, and the allegation was determined to be unfounded.

On January 28, 2004, a relative contacted CPS intake with second hand information that there was no food in the family home. The caller indicated that she had personally seen the children a week earlier, and they had looked good. There was definitive information that the paternal grandmother was in the home (recovering from an accident) and was helping to care for the children when the mother did not. The report was taken as information only (no allegations and no imminent harm assessed).

On February 7, 2004, the relative again contacted CPS intake to report that the mother had been found in bed, apparently intoxicated, and her two children were without adult supervision. The report was accepted for investigation and assigned to the same social worker who had conducted the previous investigation. A home visit was conducted March 1, 2004. At the residence were the mother, the boyfriend, and the two children. The mother would neither confirm nor deny that she had recently relapsed. The boyfriend reportedly indicated that he did not have any concerns regarding the mother's care of the children, stating that she was "a good mother." The mother

refused to agree to a CPS written service agreement, and, unlike previous cooperative behavior, the mother resisted any offer of help.

There were no further investigative or case management activities by the CPS worker, and the case appears to have gone inactive (pending completion of paperwork) by mid-March 2004.

From information obtained after the children's deaths, it was learned that the mother had by this time reported to her CSO worker that she was again pregnant. A Bremerton CSO worker made a weekend visit to the family residence wanting to check to see how the mother and the children were doing on Mother's Day. That worker observed the home to be extremely clean, neat, and comfortable. The two children appeared cared for – clean, neat, and well fed. The mother was observed to be attentive and appropriate with both children. Additionally, the CSO worker found the mother to be well groomed, and appearing in good spirits despite being tired and uncomfortable due to the pregnancy. At that time, the mother informed the CSO worker of plans to move to Kent. By the end of May 2004, the mother and her children appear to have moved to Kent, though this was not relayed to Bremerton CPS. The family connected with King County WIC.

On August 27, 2004, the boyfriend requested a law enforcement welfare check at the King County apartment of the mother. The responding officers gained entry into the apartment and observed that the mother was not drinking nor under the influence. The residence was found very clean and orderly, and the children looked cared for with no visible child abuse issues.

In late September, the last child was born in Renton. Birth records obtained post-fatality show 36-38 weeks gestation, Apgar scores of 9/9. The hospital made a referral to Public Health, and a home visit by a King County Public Health Nurse (PHN) occurred on October 11, 2004. The identified problem was related to breastfeeding. A second PHN visit occurred a week later.

On November 14, 2004, Kent Police responded to a welfare request from the boyfriend. Gaining entry to the residence of the mother, responding officers found the two boys deceased, and the surviving sibling naked and dirty, but alive. The mother had to be roused, and appeared to have been intoxicated. The mother was taken into custody. The cause of death for both children was determined by the King County Medical Examiner to be from malnutrition and dehydration.

Additional documentation obtained post-fatality by the Children's Administration and used in the fatality review included Kitsap County Sheriff Office records relating to the boyfriend and the mother, Kitsap Court documents and Judicial Information System (JIS) records, civil court documents from 2001 regarding the mother's divorce, CSO documentation, information from the Division of Developmental Disabilities (DDD), drug and alcohol treatment records for the boyfriend, and King County Public Health Nurse documentation.

The Child Fatality Review (CFR) panel also reviewed workload data from April 2003 through May 2004, regarding average workload ratios across CPS units within Region 5 Division of

Children and Family Services (DCFS). Additionally, panel members also received information from the Child Welfare League of America internet website relating to recommended standards for caseload ratios.

Information was also made available to all fatality review panel members relating to Children's Administration policies and practices, RCWs, WACs, and DSHS internet web site information regarding services that were offered to the mother prior to the child fatalities (e.g., First Steps, Family Planning Program, Maternity Support Services, Infant Case Management, and ADATSA).

The mother was charged with second-degree murder and reckless endangerment for the deaths of her two children.

A review of all Indian Child Welfare (ICW) CPS cases in Bremerton occurred after these fatalities.

A copy of the full report can be accessed at the following site:
http://www1.dshs.wa.gov/pdf/mr/review.pdf

Issues and Recommendations

I. Practice Issues

A. Issue: Regarding CPS Intake, there was a failure to ask more questions and seek additional information at the time of intake. The largest concern was the downgrading or lowering of the risk tag and standard of investigation.

Recommendation: Children's Administration continues to be committed to a statewide Intake Quality Assurance Model that addresses the issue of consistency of intake screening and risk tagging decisions.

Action: There is a plan to address at the next regional Intake Unit Meeting the following: making reasonable collateral contacts at intake, information gathering, and the routing of "addendum allegations" SERS to assigned field workers and supervisors. (The action plan to review intake information gathering etc. was completed on May 25, 2005 at a Region 5 Intake Meeting.)

B. Issue: The CPS investigation missed timelines for completing and documenting tasks. Investigative findings and assessments of the social worker were open to question and frequency and adequacy of home visits and collateral contacts. The case was left open for a long period of time.

Recommendation: Increased on-going mandatory training e.g. substance abuse with a component on binge substance abuse; mental health cross-training; domestic violence training; annual "refresher" training for CPS workers on conducting high standard of investigation. Children's Administration to monitor cases on "inactive" status statewide on an ongoing basis.

Action: Children's Administration initiated several measures to improve child welfare services in the state of Washington. Children's Administration has been in process of developing a model which separates investigations and on-going service provision/case management. Children's Administration has also requested funds to replace the CAMIS/GUI computer system. Children's Administration has ordered a statewide review of inactive cases.

C. Issue: Service Provision—CPS 1) There were few direct services provided to this family. There appears to have been a lack of effective engagement of the family with the services outlined in the service agreement.

Recommendation: Children's Administration to require domestic violence training for social workers and that such training should emphasize the importance of forging links with local domestic violence resources.

Action: Children's Administration is currently involved in on-going discussions with community partners across the state as to how to respond to domestic violence. Several statewide and regional work groups are currently underway.

D. Issue: The social worker's assessments of risk appeared to be inaccurate. There were noted concerns regarding the failure of the worker to seek information that may have improved the accuracy and confidence level of the assessments.

Recommendation: Revision of the Investigative Risk Assessment tool regarding the description of the "History of CA/N." Clarification as to the kind of information that should be summarized in this section is needed. The Practice Guide to Risk Assessment (CA) should include guidance as to the duty of workers to summarize both referral and investigative history, as well as reported history of concerns from other sources that may not have been reported to Washington State CPS (e.g. reports of involvement with CPS in other states or reports from family members indicating unreported incidents of abuse and neglect). It is recommended that Children's Administration require on-going training on risk assessment.

Action: 1) State-wide Kids Come First assessment tool refresher training and 2) Revision of the Practice Guide for Risk Assessment.

E. Issue: There was a lack of text from monthly supervisory reviews.

Recommendation: It is a suggested Region 5 practice is for supervisors to write a note in SERs when they do supervisor reviews, outlining what has been reported to them by the worker. However this is not a requirement by Children's Administration. Children's Administration should review this policy and consider seeking to meet Council on Accreditation Standards.

II. System Issue

A. Issue: Service Provider—Alternative Response System. The local ARS provider did not address basic issues identified in referrals sent to ARS.

Recommendation: Children's Administration offer training to ARS providers on client engagement and how to help clients access Indian Child Welfare services for Native American clients. Children's Administration re-examine the benchmark measures for "successful outcome" of ARS services and to clarify the role and responsibilities expected of ARS workers under contract with DSHS.

Action: Region 5 initiated cross training between ARS and Children's Administration staff. The Bremerton-Kitsap County Health District will notify the Bremerton Area Administrator of training announcements. The Children's Administration ARS Program Manager will begin to route the training announcement to the regional ARS providers when the training is relevant.

B. Issue: CPS social service system's lack of resources to adequately provide substance abuse and mental health services frequently impedes the ability of Children's Administration to serve families.

Recommendation: No recommendation.

C. Issue: Workload, staff turnover, a predominantly inexperienced work force, and isolation of the ICW/CPS unit in the Bremerton DCFS office.

Recommendation: Children's Administration continue to conduct workload studies and seek remedies for unreasonable caseloads. Children's Administration to develop a "response to workload crisis" policy that outlines specific actions and interventions that the department may take in response to emerging problems with increased referrals, vacancies/illnesses/extended leave within an office or region.

Action: ICW/CPS positions were transferred to the other CPS units in the Bremerton office. Children's Administration is to continue to conduct workload studies and will develop a "response to workload crisis."

Child Fatality Review #05-04
Region 2
Yakima Office

Case Overview

This two-week-old Caucasian male died on March 4, 2005 due to prematurity. The infant was born at Yakima Memorial Hospital on February 24, 2005. He was airlifted to the University of Washington Medical Facility due to complications from being four months premature. Upon arriving at University of Washington Medical Facility, tests confirmed that child was hemorrhaging in the brain and had become paralyzed. Hospital personnel notified assigned Children's Administration social worker that there was nothing that could be done for the child and that he was being kept alive by artificial means. The child was disconnected from the respirator, and he died at 10:15 a.m. on March 4, 2005.

Throughout this period of time the Department social worker kept in close contact with the parents, relatives, and medical personnel. It was reported by the treatment center that the mother refused treatment and stated the positive drug screen was because she was on cold medication. The relatives had been very responsive in protecting the surviving children and have initiated the process to obtain third party custody. The kinship care coordinator from Casey Family assisted the family with the custody issue.

The assigned Child Protective Services (CPS) worker had open involvement on this case prior to the birth and death of this infant due to neglect issues regarding the two surviving children. Family Preservation Services (FPS) were being provided to the family through Catholic Family Services. During this period of time the mother became pregnant and gave birth to an infant four months premature. The medical personnel stated the child only had a fifty percent chance of survival due to the very premature birth. The mother tested positive for methamphetamine at the time of this birth.

Law enforcement placed all three of her children with the uncle and aunt. These relatives completed the process for obtaining third party custody for the infant who died. The process for third party custody for the two surviving siblings has been started, but since the whereabouts of this father is unknown, will not be concluded until the publication process is completed.

A safety assessment had been completed which was signed by the father of the infant, the mother, and the uncle and aunt. Other conditions which were agreed to by the mother at that time, had not been followed. She agreed to see a substance abuse treatment provider for random urinalysis assessment and to follow treatment recommendations. In addition she agreed to go to the mental health center to complete an assessment and therapy. The mother also agreed to continue with the FPS program. A visitation plan for both parents was also included.

Mental health, substance abuse and Intensive Family Preservation Services (IFPS) were offered by the assigned social worker and refused by the family. Initially the mother agreed to substance abuse services through a drug and alcohol treatment center but then refused, becoming belligerent to the treatment center case worker. The mother refused to acknowledge that she

used methamphetamines during her pregnancy and attributed her positive urinalysis to cold medicine. The mother ultimately refused all other services.

Issues and Recommendations

I. Quality Social Work

A. Issue: Social worker did an exceptional job in assessing and attempting to engage the family into services. When the family refused services, the social worker and law enforcement officer assigned to the case spoke to the family about third party custody for the two surviving siblings. The family was in agreement to this and appropriate relatives were found and without hesitation completed the paperwork and process for third party custody.

Recommendation: No recommendation.

Child Fatality Review #05-05
Region 1
Spokane Office

Case Overview

This three-month-old Asian American male died on April 1, 2005. The Spokane County Medical Examiner indicates this fatality is due to Sudden Infant Death Syndrome (SIDS). The mother reported that she and the infant were co-sleeping in bed. The mother woke at 2:00 a.m. to feed the baby and then returned to sleep. When she next awoke, the baby was not breathing. The mother called 911, and the baby was transported to a Spokane hospital where he was pronounced dead.

A thorough case review was conducted by the Regional Child Protective Services (CPS) Program Manager. No policy or practice issues were identified. The manner of death has been determined to be SIDS which was unforeseeable. No agency action could have prevented this natural/medical death.

The mother was 16-years-old at the time of the child's death. There were five referrals in regards to her and her sister running away from home and using drugs. Her parents requested Family Reconciliation Services (FRS) several times.

This family was excited to have this child. This child was born positive for barbiturates and marijuana at birth. The mother claims she did not know she was pregnant and she received no prenatal care until the eighth month of pregnancy. Previously, this mother had an abortion when she was approximately 13-years-old.

Issues and Recommendations

No issues or recommendations were identified by the review team.

Child Fatality Review #05-06
Region 3
Everett Office

Case Overview

This four-year-old Caucasian female died on January 21, 2005 due to physical trauma. Snohomish County Sheriff's Department reported a suspicious death of a four-year-old girl. The referrer stated that the information he had was that the child's aunt reported finding the child dead at the home. The only adult at the home was the stepmother. The decedent's step-siblings were at home as well.

The referrer reported that the medical examiner was on scene. The child's exact time of death was never precisely determined, and the referrer reports the child was already in a state of rigor mortis. The child appeared gaunt, malnourished, and pale. The stepmother says the decedent had messed her pants, was bathed, and dressed in bedclothes, and sent to bed. The referrer states the child was found in jeans and a sweater. The referrer reports the child's aunt says that she found the child cold to the touch in her bed. The referrer states that the 911 call for assistance was at 11:24 p.m.

According to the referrer, the aunt claims she dropped her five-year-old hyperactive son off at her sister's at around 9:00 a.m. on January 21, 2005 and returned to the home between 6:00 and 6:30 p.m. The stepmother told the referrer that it was a really bad day, her 11-month-old was teething, her sister's boy was "hyper," and her other four children were also home.

The referrer stated that the home is a "pig sty." "The carpets are filthy and stained with dog feces, vomit, dirt, food, trash. The kitchen is dirty with dirty dishes, pots, pans, food out, etc. There are stacks of stuff everywhere, in all the rooms and on everything, papers, clothes, both dirty and clean, books, magazines, trash, garbage. There is raw meat in a baggy on the floor in the living room."

Law enforcement and medical aid were summoned to the home of the child victim at about 11:30 p.m. on January 21, 2005. The exact time of death was not precisely determined, but it was apparent to the first responders at the incident that the child was already deceased at that time. The death appeared suspicious, and the Snohomish County Sheriff's Office (SCSO) interviewed those present who were capable of being interviewed (present at the time of first response arrival were the victim's father, stepmother, maternal aunt, four small half-siblings and the son of the maternal aunt). SCSO mapped the scene, took pictures, and collected other evidence.

The autopsy determined the victim had a skull fracture that extended from the top of her head down the back of her head. Her liver had been severed in two, and there was internal bleeding. She also had some facial bruising. Medical staff determined that death would have occurred very shortly, possibly even minutes, after the severing of the liver. All those interviewed in the home denied knowing how the victim may have died. They did say the victim had possibly ingested some glue gun cleaner, and they called Poison Control about this several hours before 911 was called. Poison Control said that the stated amount of the glue gun cleaner substance

would not have hurt her, and advised giving milk to the child. The stepmother and maternal aunt also stated the victim may have fallen earlier in the evening when the stepmother was giving the victim a shower after the victim had defecated in her clothes.

The father was investigated regarding the allegation that he had been neglectful in the circumstances of this fatality. He ignored the unsanitary condition of his home in which there were many small children, and made no efforts to improve their situation. It is unknown if there was complicity with his wife, the stepmother, in attempting to conceal the cause of the child's injuries. The allegation of negligent treatment or maltreatment was founded as to the father for the neglect of his children living in the home at the time.

The stepmother also had a founded finding by Child Protective Services (CPS) for negligent treatment or maltreatment against her regarding the other children living there due to the condition of the home and for physical abuse in the death of the child.

The stepmother to the victim was investigated by SCSO and CPS for the homicide. She eventually pleaded guilty to manslaughter and has been sentenced to eight years.

The biological mother had previous CPS history in California. Her son was removed by CPS there, and she had some drug convictions. She first came to Washington CPS attention in 2000 when CPS received a referral that she tested positive for cocaine when pregnant with the decedent. When she was born in February of 2000, both the mother and infant tested positive for cocaine. CPS filed for dependency and placed the child into care.

For the next three years, the Department attempted to remedy the biological mother's parenting difficulties and permanently reunite her with her daughter. The first reunification was only a few days after the birth when the Department asked the court to approve her return to her mother while she and infant were in an inpatient recovery program together. Reunifications were successful only for limited periods of time. After four failed attempts at reunification and seven different foster care placements, it became apparent that this child would have to have another permanent plan.

This child, both parents claimed, was the product of a one night relationship between the biological mother and the biological father, who was married and had other children. The father remained with his wife and other children during the mother's pregnancy and during the years the decedent went back and forth between the care of her mother and foster care. The father had little to no involvement in the planning for the decedent. He said later that he had believed the mother when she told him that she was going to get the child back soon and then he could visit with her. However, in May of 2003, the Department filed a petition for termination of parental rights on both parents. This was the beginning of a plan to move toward a goal of adoption for this child, as it appeared that neither parent was able and willing to raise her. It was at this time the father stepped forward and said he was interested in having her placed with him. He was living with his wife and three children at the time.

The father then came forward to comply with services the court required of him if his daughter was going to be placed with him. He obtained a chemical dependency evaluation, psychological

evaluation, and attended parenting classes with his wife. In May of 2003, a home study of this home was conducted by an adoption home study worker. It consisted of one visit in which the worker was favorably impressed as she concluded her report with a recommendation that this child begin visits with her father and be placed there in the immediate future "barring any additional adverse information." The father's criminal history consisted of two felony convictions for forgery and burglary. There was no criminal history found on the stepmother. A review of the family's CPS history revealed one information-only referral (not assigned for investigation). This child was eventually placed in this home in November of 2003. There was some limited supervision of the placement by both the private child placing agency involved in the case and the assigned social worker. Services were offered, accepted, and included home visits and general case management by the private agency helping with the oversight of the transition into the home of her father. It was agreed by the review team that the offer of a Public Health Nurse into the home, had it been accepted, may have given an alert about her deteriorating condition.

The dependency was dismissed in November of 2004 as the father, by that time, had established a parenting plan and gained custody of his daughter through family court. The Department closed her case at that time.

On January 21, 2005, the aid car was called to the father's home. It was determined that this four-year-old was dead. The stepmother later confessed to having beaten her to death in a fit of rage over the child having soiled her pants.

Issues and Recommendations

I. Policy Issues

A. Issue: The social workers involved in this case were at a disadvantage in not having full access to criminal history information. Having full access would have provided more information about father's offenses. The current system used to obtain criminal histories for CPS purposes is inadequate as there are often omissions in the report.

Recommendation: This review team recommends there be a statewide review of access by CA to criminal histories. The review conducted should include participation by Washington State Patrol and state legislators.

B. Issue: There was no reunification assessment completed prior to placement with the father and stepmother, as it was not required under the current policy when returning the child to the home of the parent who was not the parent from which the child was removed.

Recommendation: The review team recommends a change in policy to require reunification assessments when considering placement of a child with any parent after having been in out of home placement.

C. Issue: The review team believed the in-home dependency (CA Policy 01-02) policy was unclear. The review team understood its intent was to direct the number of times a child is to be visited in the home when the child is being returned to a home from which s/he was taken and parental deficiencies were being remedied. It was not clear to the social worker and supervisor if this policy was to be followed when the child was being returned to the other parent.

CA Policy 01-02 states, "...(this policy)...also does not apply when a child has been returned to a parent with no allegations of abuse or neglect concerning that parent. For example, if a child is placed with his/her non-custodial parent following the removal of the child from the custodial parent, when there has been no allegation that the non-custodial parent has ever abused or neglected a child, this policy does not apply."

The review team believed the provision in the in-home dependency policy left it rather ambiguous if the monitoring requirements should apply in this case.

Recommendation: There is a new policy that clearly states, visits to children in their own homes should occur every thirty days. This review team recommends that this new policy carry over the more stringent monitoring requirements of CA Policy 01-02 (two visits to the child two times per month for the first six months home, and once per month thereafter for small children until the case is closed). This policy clearly applies to a child returning home to either parent after out of home placement.

II. Practice Issues

A. Issue: There were inadequate descriptions of the decision-making process involved in several critical events documented in this record. For example, documentation of the decision making-process to dismiss the termination petition was not clear in the record.

Recommendation: There should be additional training for social workers and supervisors on clear documentation of the background and reasoning in the decision-making process on crucial junctures in cases. These would be, for example, decisions to petition the court for dependency or termination of parental rights, or to request the court to withdraw petitions already filed. It would also include reasoning on placement decisions that do not flow logically from the narrative.

B. Issue: Although there were many instances in the record where references were made to visits with the decedent that were supervised by the Home Support Specialist (HSS), there was little to no documentation by HSS of those visits, or any other of her activities on this case.

Recommendation: Supervisors of Home Support Specialists should ensure their staff are documenting their work with families.

C. Issue: The chemical dependency evaluation for the father was based on a self report which left out pieces of information that, had they been known to the evaluator, would likely have led to a different recommendation for treatment.

Recommendation: The father's chemical dependency assessment did not go through the established protocol with the chemical dependency liaisons established for this purpose. If the father had been referred through this program, there would have been an expanded assessment, with collateral information available to the evaluator, and a urine test. It is recommended that refresher training be made available to social workers/supervisors regarding how to access this expanded evaluation.

D. Issue: It was noted by several people involved in this case that services were needed for this child both in her previous placements and after placement in the home of her father. Therapy was never made available for her through any of her placements, despite very problematic behaviors. The father's family did not receive services for her after the last home visit of the assigned social worker in May 2004, and the family did not follow through on services they had planned to access.

Recommendation: Supervisors, in their monthly review of cases with their social workers, should specifically address the service needs of their client families and how these may best be met.

E. Issue: Staffing levels were inadequate at the time of this incident. Case coverage during vacations and uncovered supervisory and line positions contributed to excessive workload.

Recommendation: CA needs policy to address vacations and unfilled positions, including post-retirement buyout of vacation and sick time, which leaves those positions vacant during that time.

F. Issue: This review team, having heard from the social work staff that were close to this tragedy and from some that were affected more peripherally, believes staff suffered a trauma from this event that was not addressed quickly enough. The Employee Assistance Program debriefing was helpful, but the team perceived a need for something sooner.

Recommendation: The team recommends that regional protocol be redesigned to assure more immediate and supportive response for staff immediately following a critical incident such as this. This would be in addition to, and preceding, the support of the Employee Assistance Program.

G. Issue: This child was in a total of seven separate receiving or foster homes over the three and a half years prior to her placement with her father. It is unclear from the record why, on the several times when she returned to care from her mother's home, she was not placed with the same foster home she had been placed in previously.

Recommendation: The review team recommends that when a child is returned to care for whatever reason, there be a discussion and documentation of why s/he could not be returned to a foster or relative home s/he had been previously placed.

III. System Issues

A. Issue: A law enforcement regional drug task force had information regarding this family that CA did not. Had CA been aware of this information, there would have been greater scrutiny of the household as a safe placement for this child.

Recommendation: The review team recommends that a meeting be arranged between CA and the law enforcement regional drug task force to include, at a minimum, the CA liaison to the task force and her supervisor to discuss the development of a system to identify common clients at most risk.

B. Issue: Removed from her mother at birth, this child went through many transitions back and forth in placements between her mother and foster care. There was delay in identifying and implementing a permanency planning goal for her. This was in part due to intense efforts by parent focused advocacy groups for the child to be returned to her mother, despite evidence that the mother's parenting abilities were severely compromised. Collaboration was difficult due to the differing perspectives of CA and the parent advocacy group.

Recommendation: CA should do outreach and education with parent focused advocacy groups providing chemical dependency case management to work toward an environment that not only focuses on the interests of the parent, but also the best interests of the children. This would include initiating a conversation with CA regional staff, Division of Alcohol and Substance Abuse regional staff, Snohomish County Alcohol/Drug Coordinator, and the executive personnel of agencies providing chemical dependency case management. The purpose of this conversation would be to come to an understanding that the best interest of the child must be paramount, while simultaneously considering the parents' interests. It is important the alcohol and other drug treatment community recognize that while taking addictive substances out of their lives is a significant hurdle for a parent, there may remain other obstacles that compromise safe and effective parenting.

IV. Contract Issue

A. Issue: The case record shows that a private agency was paid approximately $175.00 per month by CA for the six months beginning when this child was placed with her father in November of 2003 for follow up services to include, at a minimum, one home visit per month. The records sent to CA from the private agency's record state that all of their services to this family ended on February 3, 2004. However, payment continued through May of 2004.

Recommendation: The review team recommends that this case be referred for overpayment and contract monitoring issues.

Child Fatality Review #05-07
Region 2
Tri Cities Office

Case Overview

This nine-year-old Caucasian male was pronounced dead on June 8, 2005 due to septic shock from a ruptured appendix.

On June 8, 2005, it was reported that he got out of the bathtub, turned yellow, and passed out. He was taken to the emergency room at Lourdes Medical Center. There were additional concerns that both the decedent and his five-year-old brother were physically abused, and that there was marijuana use in the home. Contacts were made with others involved with the family.

The emergency room doctor indicated that she made contact with the school nurse, as the mother had reported that the decedent had been vomiting and had diarrhea for the past three days.

The school nurse reported that she was concerned about the family in regard to physical abuse based on some anonymous phone calls although was unable to find any specific allegations. A visit was made by the school nurse on June 2, 2005, and the decedent's mother would not allow her in the home. Contact was also made with the mother's Financial Services worker at the Community Services Office (CSO). They had been working closely with the mother. The mother was reported to be in outpatient treatment, but recently was non-compliant. She had also refused the involvement of Safe Babies Safe Moms through the Benton Franklin Health Department.

The following is from the assigned Child Protective Services (CPS) social worker's findings letter: "There appears to be enough evidence that the mother knew that the decedent was having more than a stomach ache. When he arrived at the hospital, the decedent was already coding. It was reported that he had been vomiting and had diarrhea several times a day for three days. The coroner's office reported that his stomach was "full of pus" and "there would have been plenty of warning signs and child would have had severe abdominal pains." The pathologist reported that had the child been poked in the abdominal area, the pain would have been "intense enough to cause concern." The mother's neighbors reported that they told the mother that the decedent needed to go to the doctor because of the pain. The decedent had mentioned to the neighbor that it could be his appendix or pancreas and it was pain and not nausea. The neighbor passed this on to the mother. When the neighbor went to the home to check on the decedent, the mother told him that "he is all yellow and white and looks like he is going to die" however would not take him to the doctor because it was only a stomach ache. There is concern that the mother had been smoking marijuana and that is likely what clouded her judgment. She tested positive for marijuana on May 18, 2005 and the neighbor saw a big bag of pot in the home the weekend prior to the child dying. The mother also tested positive for methamphetamine (meth) on June 22, 2005 and it is likely that she has a problem with meth as well. The mother had also not made any attempts to contact any medical professionals and did not have a primary care physician although she was instructed to get one. Had she been able to contact a medical professional, the child may not have died."

The decedent's siblings were seen at Lourdes Medical Center where they were given a clean bill of health.

On June 20, 2005, the assigned social worker staffed this case with the Assistant Attorney General's office. It was decided that due to the risk factors, a dependency petition would be filed for out of home placement. The children were placed into protective custody on June 21, 2005. The decedent's sister is currently residing in foster care and his brother is currently in relative placement with the grandparents.

The mother had been involved with 15 prior referrals received by the Department. Two of those were founded for neglect. One occurred on September 3, 2002, when the decedent and his brother were allowed to be around a known sex offender. The other occurred on November 23, 2004 when the mother allowed her boyfriend, who is the father of her youngest child, to physically abuse both boys. There were four referrals which were unfounded. These referrals alleged physical abuse and neglect. The other nine referrals were information only and referred to Alternative Response System (ARS) due to being low risk and a third party report. These referrals alleged that the mother's home was filthy, the children were dirty and being locked in their rooms, marijuana and methamphetamines was being used in the home, and that the mother was using drugs while she was pregnant. There were concerns that at least two of the referrals may have been maliciously reported.

Services offered to this family include mental health services, parenting classes, child care, Intensive Family Preservation Service (IFPS)/Family Preservation Services (FPS) and substance abuse treatment. The mother refused all services except substance abuse services.

The mother entered into drug/alcohol treatment on October 5, 2005 after initially refusing all suggested and recommended services by the Department. In addition to addressing her substance abuse problem at this facility, the mother is also receiving grief counseling and parent education.

Issues and Recommendations

I. Practice Issue

A. Issue: Communication between the CSO and Children's Administration

Recommendation: Selected representatives from the CSO (Pasco & Kennewick) and Children's Administration will collaborate in developing a working agreement to enhance mutual client case planning; exchanging of information; the reporting of child abuse and/or neglect and any other area deemed necessary and needed. The Richland office will continue to conduct CPS presentations to the CSO when requested.

B. Issue: Referral screening

Recommendation: More scrutiny will be given to referrals received in which there is significant case history. Intake workers will continue to staff with supervisor on chronic neglect families.

Child Fatality Review #05-08
Region 2
Tri Cities Office

Case Overview

This three-year-old Caucasian male was pronounced dead on August 19, 2005 due to drowning in a swimming pool.

The family of the deceased child became homeless and was living at the Vineyard Inn motel in Pasco, Washington. The mother left the premises of the motel and left the child in the care of his older siblings, a ten-year-old sister and a 15-year-old brother. The siblings lost track of the decedent and when they looked for him, found him in the motel swimming pool. An ambulance with officer assistance responded to the scene. The child was transported to Lourdes Medical Center where he was pronounced dead.

There were 15 prior referrals on this family from 1998 to the present. In reviewing the case history of this family, there is a pattern of neglect (supervision) of the deceased child. Nine referrals since this child's birth are neglect reports which identify him as a victim. There is also a consistency in the reporting of the mother's drug use. There are four referrals that mention alleged drug use by the mother. The family moved often, which led to some difficulty locating their whereabouts and prohibited the Department from making face to face contact with the child on at least one occasion.

Child care and home based services were offered to the family by the social worker, but were declined by the family. An offer to help build a fence via home based monies was declined due to the family moving to a different residence.

Issues and Recommendations

I. System Issue

A. Issue: Better coordination between Children's Administration and law enforcement in obtaining information of possible child abuse and neglect situations to better expedite response time and assessment of children.

Recommendation: Law enforcement will contact Central Intake after hours and the local office during regular business hours to inform Children's Administration of incidents they encounter that involve child abuse and/or neglect. This will substitute for the primary practice of law enforcement mailing or faxing incident reports to local offices. This practice will assist Children's Administration social workers in responding to incidents quicker and enhance assessments of child risk and family needs. A letter will be sent to each shift sergeant in each law enforcement agency in the Richland jurisdiction to inform of this preferred practice change.

II. Practice Issue

A. Issue: The mother of the deceased child was not charged for negligence (proper supervision of a young child) even after law enforcement was directly involved in responding to five calls of the child wandering the streets without supervision.

Recommendation: More consideration should be given to filing charges on incidents that are repetitive and involve the safety of a young child.

B. Issue: CPS investigative practice

Recommendation: Supervisors will continue to encourage social workers to utilize: 1. Family Team Decision Making staffing; 2. CPS family assessment; 3. Staff screening decisions with supervisor for chronic neglect referrals; 4. Guidelines to locate children to ensure diligent efforts have been made.

C. Issue: Motel pool access and adult supervision. Motel management of the Vineyard Inn in Pasco, Washington needs to enforce their current policy of proper adult supervision for minor children utilizing their pool and/or secure access to their pool to prevent accidental drowning.

Recommendation: *Write a letter to Vineyard Inn management indicating the recommendation of the review team.*